ERIC BUCHANAN AND ASSOCIATES

ERIC BUCHANAN & ASSOCIATES, PLLC
Attorneys at Law

ERISA & DISABILITY BENEFITS NEWSLETTER

VOLUME 5, ISSUE 1, JANUARY 2013

ABOUT OUR FIRM

Eric Buchanan & Associates, PLLC is a full-service disability benefits, employee benefits, and insurance law firm. The attorneys at our firm have helped thousands of disabled people who have been denied social security disability benefits, ERISA LTD benefits, health insurance, life insurance and other ERISA employee benefits, as well as private disability and health insurance benefits.

For more Information about Eric Buchanan & Associates, PLLC, visit our website at www.buchanandisability.com.

Eric L. Buchanan and R. Scott Wilson are certified as Social Security Disability Specialists by the Tennessee Commission on CLE and Specialization.

THE ANATOMY OF AN ERISA LONG-TERM DISABILITY POLICY: HOW TO READ IT AND UNDERSTAND IT - BY: JULIE E. MOYA

In an ERISA long-term disability ("LTD") case, one of the most important parts of the case is understanding the terms of the ERISA policy or plan. Thus, a lawyer who practices in this area must have the skills to effectively read an ERISA LTD policy or plan, to identify portions that are relevant to his/her client's case, and to understand those portions. This newsletter will discuss the basic "dos" and "don'ts" of reading and understanding an ERISA LTD policy or plan.

First, you need to obtain a complete and accurate copy of the ERISA LTD policy or Plan. Your client, or you on behalf of your client, should write a letter to the Plan Administrator of the plan (usually the employer) asking for a complete copy of the LTD plan, as well as any other documents, such as the summary plan description, and any insurance policy, if it is separate from the plan. The employer, as Plan Administrator, has a legal obligation to provide the documents within 30 days of a written request under ERISA § 502(c). For a full discussion of the rules and law that apply to the client's right to obtain these documents, see our paper on our website at www.buchanandisability.com/helpful-resourcesandarticles/ERISA-502c-actions/.

Once you have a copy of the policy or plan, let's talk about what *not* to do. Do not begin by trying to read the policy line-by-line and from start to finish (at some point this will be necessary, but do not *begin* this way). Chances are you will get bogged down and potentially miss the key parts that really matter. Instead, try the following suggestions that will help you think as you read and will maximize your overall understanding of the policy.

Also, when you review the policy, it is important to have some other basic information handy, such as the actual denial letters in the case, and some basic facts, such as whether the claimant has been paid benefits for a while, or when they stopped working, etc. As we explain below, it also helps to have a basic understanding of what other benefits or income the client has. With that basic information in hand, you are now ready to review the policy.

The first thing we look at is the contractual period of limitations, which is the time set out in the policy or plan by which a law suit must be brought. While ERISA generally adopts the analogous state law statute of limitations for a breach of contract case to limit when a lawsuit can be filed in an ERISA benefits case, most courts will limit the time even more if the ERISA policy or plan has a time limit for filing a lawsuit. As the court in *Massengill v. Shenandoah Life Ins. Co.*, 459 F. Supp. 2d 656, 660 (W.D. Tenn. 2006), explained, "Courts have also recognized that in the ERISA context, as with other types of contractual arrangements, the parties may agree upon a shorter limitations period, so long as the period is not unreasonably short." *See, also Wilkins v. Hartford Life & Accident Ins. Co.,* 299 F.3d 945, 948 (8th Cir.2002); *Northlake Reg'l Med. Ctr. v. Waffle House Sys. Employee Benefit Plan,* 160 F.3d 1301, 1303-04 (11th Cir.1998); and *Doe v. Blue Cross & Blue Shield United of Wis.,* 112 F.3d 869, 873-74 (7th Cir.1997).

Often, if the LTD benefits are provided through an insurance policy, the policy will use model language, usually required by state law. The way the policies are written typically requires an attorney to look at several different parts of the policy to calculate when a law suit must be filed. The basic contractual period of limitations in most insured policies limits the time to file a lawsuit to three years from when "proof of loss is due." When "proof of loss" must be filed is often defined somewhere else in the policy, and is typically 30, 60, or 90 days after benefits are due to begin, which is at the end of the "elimination period." Again, you must look somewhere else in the policy to find out the elimination period, which is usually 180 days, but sometimes 90 days or something similar, from the time the person becomes disabled to the time benefits begin. Thus, in a typical policy where the elimination period is 180 days, and proof of loss must be filed within 90 days of the end of the elimination period, and the time for filing a lawsuit is three years from when proof of loss is due; thus, in those policies, a lawsuit must be filed within three years and 270 days from when the person became disabled.

However, if the ERISA plan is self-funded, it is not subject to state insurance law, and need not use model language to limit the time for filing a claim. Often, many self-funded plans will use language limiting the time to so many days after the company issues a "final denial" on the claim. These time limits can be very short, so it is important to read the plan quickly and carefully. For example, a limitations period as short as 90 days from the time of a final denial has been held to be reasonable. *Northlake Regional Medical Center v. Waffle House System Employee Benefit Plan*, 160 F.3d 1301, 1304 (11th. Cir. 1998).

Next, we review the terms of the policy setting out the benefits to be paid, and look to see what other benefits are an offset to the policy. Unfortunately, a large percentage of the cases that we review are not financially viable, no matter how disabled the person is, or how erroneous the insurance company decision is, because almost all policies offset for other benefits, such as social security disability benefits and workers' compensation benefits which can result in really low "net" benefits for the client.

As a basic rule, we assume in most LTD cases that, if the client is disabled enough to have a good LTD claim, the person will also likely win his or her social security disability case. Of course, there are exceptions for cases where the definition of disability only requires the person to be disabled from their own occupation, but in most cases, the person must be disabled from any occupation, at least after two years. So, we look to see if the policy offsets for social security benefits (most do), and make and estimate how much the person's net LTD benefits would be, to see if the case is worth working on. Further, most policies offset for not just the claimant's social security benefits, but also for any benefits paid on the person's account for the person's dependents. In the majority of policies, which offset for all social security benefits paid, including those for dependents, policies refer to those as "family" benefits. In the minority of policies, it may only offset for the claimant's individual benefits, which many policies refer to as "primary" social security benefits.

Another common offset is benefits for any workers' compensation case that covers the same time period, as well as disability pension benefits, and sometimes ordinary pension benefits. More recently some policies have started allowing for offsets for money received from third-party tortfeasers that caused the injury that made the person disabled. Thus, in order to determine if a case is worth working on, you need to find out what other benefits the client is receiving or will be eligible for, and compare those to the policy language.

Once we have determined the case is financially viable, we next look at the decision letters from the insurance company or ERISA plan, and look to see if the decision relied on any specific language in the policy or ERISA plan, to determine whether the decision actually relied on the correct policy language. We have seen a surprising number of cases over the years where an insurance company has applied language that is not actually found in the policy, or is worded differently, which can make a big difference in some cases.

Next, if we have not already done so by comparing the language in the decision letter, we look at the definition of disability in the plan. As explained above, some better policies define disability as the inability to perform the person's own occupation, while many others only pay benefits for a year or two for the inability to perform the claimant's own occupation, but then the person must be unable to perform any occupation.

Further, the specific language of those definitions can be important. Some are very limited (and favorable to the insurance company) and might say that a person is only disabled if he or she is unable to perform all material

duties of an occupation, which some insurance companies have argued means if they can perform one duty, they are not entitled to benefits. Some policies are more generous, and favorable to the claimant, and might say that the person is disabled unless they have the ability to earn a certain percentage of their pre-disability earnings, such as 60% or 80%.

There are other plan provisions that should be reviewed, that may come up in the case as you go forward. Some other key plan provisions, and why they matter, are:

1) Look for the "effective date of coverage." If the company/employer purchased a new policy recently, it usually takes a while for the policy to become effective, so your client's disability needs to begin after the policy is in effect.

2) If the denial decision relies on a claim that a condition is preexisting, read the specific definition of what is a preexisting condition. Many of those provisions actually only exclude conditions that were treated during a certain time prior to coverage, and really should be considered "recent treatment" provisions. We have seen several cases where an insurance company has denied a claim for a condition that a person indisputably had in the past, but received no treatment for or exhibited no symptoms of during the "look back period." Compare the language with the facts of your case.

3) Look for a summary plan description ("SPD"). Most policies put this document at the front or back of the policy (rarely in the middle), or issue a separate document. An SPD is more than a helpful summary of important policy information (such as the policy's funding source, the address for service of process, etc.). An SPD is a *mandatory* summary. 29 USCS § 1022. The ERISA statute states that insurers "shall" provide an SPD, and lists in detail what needs to be in the SPD. *Id*. Make sure the insurer has complied with the Statute. *Id*. If the SPD and the policy conflict, which provision did the insurance company rely on? In most cases, the actual policy or plan should control over the SPD, but some cases hold that a plan participant may have some arguments when he or she reasonably relied on a provision in the SPD.

4) Check the "classes" of coverage or policy "options." You may think you are reading only one policy, but that policy might really be two or three policies thanks to different terms that apply to different classes of employees.

5) Look for the monthly benefit definition. It may not always be a straightforward percentage of predisability earnings. Some policies have a defined benefit, or have additional optional coverage that a person may have signed up for.

6) Look for any "maximum" or "minimum" benefit. This information can make or break a case. For example, a seemingly worthless case could be a moderately valuable case if there is a minimum benefit and the person is very young and has a long period of time to accumulate benefits. At the other end, a very high earner's benefits may be limited to less than the percentage found in the policy if the maximum benefit is set too low.

7) Look for the maximum period of payment, a.k.a., how long your client is entitled to benefits. This is often until age 65, but more policies allow for benefits up to "normal retirement age" as defined by the Social Security Act. Also, many policies have special rules for people who become disabled after age 60 or within five years of the maximum benefit period.

8) Look for limitations on benefits for specific impairments. For example, many policies limit benefits to 24 months for mental, nervous, or "self-reported" conditions. You need to know if a provision like this applies to your client.

This list is not exhaustive; there is no substitute for time and attention. However, hopefully, these guidelines will help you effectively read ERISA LTD policies, to identify the portions that are relevant to each client's case, and to understand those portions.